

Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications Prior Authorization Request Form

DO NOT	COPY FOR FUTU	RE USE. FORMS ARE	UPDATED FREQUEN	ITLY AND MAY BE	BARCO	DED.
Member In	Provider Information (required)					
Member Name:			Provider Name:			
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City:	Sta	te:	Zip:
	M	edication Inf	ormation (resu	uirod)		
Medication Name:			Strength: Dosage Form:			
Wododion Namo.			Directions for Us		Doodgo	1 01111.
☐ Check if request is for cont	inuation of thera	ру				
		Clinical Infor	mation (require	ed)		
Select all that apply:			Tricker of the comment	ou,		
Episodic Migraines:						
☐ The recipient has a	documented di	agnosis of episodic	: migraines			
☐ The recipient is 18 y		•	migranioo			
☐ The recipient has fo	•		but no more than	14 hoodacho d	ave nor	month
□ No other CGRP Inh			but no more than	14 fieadache d	ays pei	monu
			ent has all of the fo	llowing:		
☐ If the request is for				_		
	-	•	=		acne rred	quency and/or intensity
	-	aine medications (e.g				
Indicate which of the fo	llowing nave be		arter a two-month	trial or the recip	ient nas	a contraindication:
Amitriptyline		Venlafaxine		Divalproex		
Topiramate		Atenolol		Propranolol		
Nadolol		Timolol		Metoprolol		
Chronic Migraines:						
The recipient has a	documented di	agnosis of chronic	migraines			
☐ The recipient is 18 y	years of age or	older				
☐ The recipient has be	een evaluated f	or medication over	use headache (M0	OH)		
If the recipient has a			•	•	ide a tai	per of the offending
medication	J	,	•			9
☐ The recipient has ≥	15 headache d	avs per month, of v	vhich at least eigh	t must be migra	ine davs	s for at least three
months		,	3	3	,	
No other CGRP Inh	ibitor will be use	ed in combination				
The medication will	not be used in	combination with B	otox (onabotulinui	mtoxinA)		
If the request is for	continuation of	therapy, the recipie	ent has all of the fo	ollowing:		
 A documented pos 	itive response to	the requested agent,	demonstrated by a	reduction in head	ache fred	quency and/or intensity
A decrease in the u	use of acute migra	aine medications (e.g	., NSAIDs, triptans)			
 Continued monitori 						
Indicate which of the fo	-	en tried and failed	after a two-month	trial or the recip	ient has	a contraindication:
Amitriptyline	J			Divalproex		
☐ Topiramate				Propranolol		
□ Nadolol	_	Timolol				
	_					

FA-151 08/31/2020 Page 1 of 2

Select a	all that apply:						
Acut	te Migraines:						
	The recipient has a documented diagnosis of acute migraine with or without aura						
	The recipient is 18 years of age or older						
	The prescribed dose will not exceed two doses per migraine and treating no more than eight migraine episodes per 30 days						
	☐ The recipient has had at least one trial and failure of a triptan agent						
	Document triptan agent:						
	If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent						
Epis	odic Cluster Headaches:						
	The recipient has a documented diagnosis of episodic cluster headache						
	The recipient is 18 years of age or older						
	☐ The recipient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-						
	free periods lasting at least three months						
	☐ If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent, demonstrated by a reduction in headache frequency and/or intensity						
Are there	e any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to ew?						
Please no	ote: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.						

Clinical Information continued (require

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FA-151 08/31/2020 Page 2 of 2